Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Image Medical Center

Respondent Name
Old Republic General Insurance

MFDR Tracking Number
M4-14-2219-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These denials are invalid as the fee schedule allows for greater than $0.00. Also bills were submitted on 11/7/13 as reconsideration therefore shall not be denied as a duplicate."

Amount in Dispute: $705.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson, P.O. Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8 and 13, 2013	97110, 97140	$705.88	$202.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers compensation state fee schedule adjustment
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 18 – Duplicate claim/service

Issues

1. Support the disputed services are eligible for additional payment?
2. What is applicable rule to determine maximum allowable reimbursement?
3. Is the requestor due additional reimbursement is due?

Findings

1. The carrier denied the disputed services as, 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;… and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the submitted medical bill finds the provider submitted in compliance with division rules. The carrier's denial is not supported.
2. Per 28 Texas Administrative Code §134.203(c)(1) states (c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." "(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (current year conversion factor)." The maximum allowable reimbursement calculations will be as follows;

Date of Service	Submitted Code	Billed Amount	Allowable	Amount Paid	Amount Due
May 8, 2013	97110	$285.44	$52.22	$0.00	$52.22
May 8, 2013	97140	$67.50	$48.89	$0.00	$48.89
May 13, 2013	97110	$285.44	$52.22	$0.00	$52.22
May 13, 2013	97140	$67.50	$48.89	$0.00	$48.89
		TOTAL	$202.22		$202.22

3. The MAR for the disputed services is $202.22. The carrier previously paid $0.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $202.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $202.22 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 17, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.